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The right to health : a human rights perspective with a case study on Greece

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PART I

FROM THEORY TO PRACTICE

2 The Right to Health in Human Rights Law and its Connection to other Human Rights

2.1. INTRODUCTION

However phrased and although there are scholars who hold diverse views on its nature and scope, health as a right is recognised worldwide.¹ International and regional human rights regulations define health as a right as well as impose a range of obligations on States parties for the fulfillment of this right. The formulation of a right to health in various human rights documents is of importance in that it can contribute to an understanding of the normative framework of the respective right and of the nature of state measures required for realizing this right. As such, Chapter 2 draws attention to key formulations of the right to health adopted in human rights law and its relation to other human rights. Chapter 2 is primarily divided into three sections, namely the international, regional and national, and examines key instruments that add substance to the content of the right to health. In particular, after an analysis of the key formulations and sources of the right to health in international law in section 2.2, regional instruments in Europe that lay down a right to health will be discussed. In addition, section 2.4 addresses the right to health as it appears in national context, namely in national constitutional law. Finally, in section 2.5 the connection of the right to health to other human rights will be identified.

2.2. HEALTH AS A RIGHT AT THE INTERNATIONAL LEVEL

Given the significance of health as a vital feature of the human condition (see section 1.1), health has been recognised as a right in numerous international documents (see below sections). For instance, at UN level, the World Health Organisation (WHO) has observed that every country in the world is a party to at

¹ See, e.g., V.A. Leary, 'The right to health in international human rights law', *Health and Human Rights* 1994, Volume 1, Number 1, pp. 25-56, p. 26; T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, Volume 30, Issue 3, pp. 643-662.

least one human rights treaty that deals with health-related rights, including the right to health.² In line with this statement of WHO, Navanethem Pillay, the former UN High Commissioner for Human Rights, underlines that ‘the right to health is a fundamental part of our human rights’.³ This argument has been also defended by academics. Lawrence O. Gostin, for example, considers the right to health as ‘perhaps the most important social and economic entitlement’⁴. Similarly, John Harrington and Maria Stuttaford point out that ‘the human right to health has moved to the centre of political debate and social policy across the globe’.⁵ Meanwhile, there are scholars who have been critical of the right to health and its various aspects. For instance, Jennifer Prah Ruger holds the view that ‘one would be hard pressed to find a more controversial or nebulous human right than the ‘right to health’.⁶ Therefore, the following analysis will be confined to an outline of the key international formulations of health as a right in an effort to reveal its various expressions as well as to elucidate the key features of this right in international law and the state obligations that derive from this legal framework. Hereto, the international documents that will be examined include, *inter alia*, the WHO Constitution, the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) as well as other UN conventions relating to specific population groups.

2.2.1. WHO CONSTITUTION, UDHR & ICESCR

1 *The WHO Constitution*

In 1946, the World Health Organization adopted the first right to health provision worldwide in the preamble of its Constitution.⁷ In particular, States declared that

² WHO, *25 Questions and Answers on Health & Human Rights*, Health & Human Rights Publication Series, Issue No. 1, Geneva: World Health Organization 2002, p. 12.

³ N. Pillay, ‘Right to health and the Universal Declaration of Human Rights’ *Lancet* 2008, Volume 372, Issue 9655, pp. 2005-2006.

⁴ L.O. Gostin, ‘The Human Right to Health: A Right to the “Highest Attainable Standard of Health’ *Hastings Centre Report* 2001, Volume 31, Issue 2, pp. 29-30, p. 29.

⁵ J. Harrington & M. Stuttaford, ‘Introduction’ in: J. Harrington & M. Stuttaford (eds) *Global Health and Human Rights: Legal and Philosophical Perspective*, London: Routledge 2010, pp. 1-11, p. 1.

⁶ J.P. Ruger, ‘Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements’ *Yale Journal of Law & the Humanities* 2006, Volume 18, Issue 2, pp. 273-326, p. 273; J.P. Ruger, *Health and Social Justice*, Oxford: Oxford University Press 2010, p. 119 (citing relevant studies).

⁷ The WHO Constitution was adopted by the International Health Conference held in New

‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition’⁸, defining health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.⁹ In conjunction with the definition of health as a right, the preamble to the Constitution underlines, *inter alia*, the connection between unequal development of States and the promotion of health and control of (communicable) diseases; the significance of the healthy development of the child as well as of health-related knowledge of individuals, of informed opinion and active co-operation of the public for the improvement of their health.¹⁰ The WHO definition of the right to health was influential in articulating the right to health language included in various international human rights treaty provisions.¹¹

In literature, it is pointedly argued that WHO by expressly including the mental and social dimensions of well-being adopted an expansive definition of health and therefore extended the roles and duties of health professionals and their relation to the society at large.¹² Such a definition, though encapsulates the dimensions of the conditions of health (i.e., physical, mental and social)¹³, has received criticism as being too broad for law and policy making, in that it likely provides no useful tool to make this right operational, namely a reasonable and workable standard to judge the health of an individual and/or a population.¹⁴ As such, one may agree with the position that this right as defined by WHO is simply not practical and

York, from 19 to 22 July 1946, signed by the representatives of sixty-one States on 22 July 1946, two years before the UDHR was proclaimed, (Official Records of the World Health Organization, 2, 100), and entered into force on 7 April 1948.

⁸ Ibid., Preamble to the Constitution.

⁹ Ibid.

¹⁰ Ibid.

¹¹ B.C.A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp/Oxford: Intersentia/Hart 1999, p. 36.

¹² J.M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini & H. Fineberg, ‘Health and Human Rights’, in: J.M. Mann, S. Gruskin, M.A. Grodin & G.J. Annas (eds.), *Health and Human Rights: A Reader*, New York/London: Routledge 1999, pp. 7-20, p. 8.

¹³ See also, earlier scholars, e.g., H.E. Sigerist, *Medicine and Human Welfare*, New Haven/London: Yale University Press/Oxford University Press 1941, p. 100; See also, section 3.2.

¹⁴ See, e.g., J.P. Ruger, *Health and Social Justice*, Oxford: Oxford University Press 2010, p. 122; Ibidem supra note 11, pp. 23 and 32-36; E.D. Kinney & B. Clark, ‘Provisions for Health and Health Care in the Constitutions of the Countries of the World’ *Cornell International Law Journal* 2004, Issue 37, pp. 285-355, p. 289; Ibidem supra note 4, L.O. Gostin 2001, p. 29.

realistic when it comes to be applied, because of its high level of abstraction as to its content. Indeed, in practice, this argument is advocated well if one considers that WHO has partly failed to mainstream the broad-based right to health in its own health policies and programmes¹⁵, with the exception its 2005 International Health Regulations (see section 2.2.3) which seem to offer an international legal approach to health.

2 ARTICLE 25 § 1 UDHR

Early in the history of the UN, the Universal Declaration of Human Rights (UDHR) was adopted by the UN General Assembly in 1948.¹⁶ The UDHR acknowledges health as a right in Article 25 § 1 differently than the WHO Constitution. Particularly, Article 25 § 1 provides that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control’.¹⁷

The final wording of the UDHR -Article 25-, which was the result of many debates and several proposed drafts by the drafting committee, was adopted with only minor amendments by the General Assembly.¹⁸ The right to health as such is not incorporated in the text of the respective provision of the UDHR. On the contrary, the UDHR includes in its Article 25 § 1 health indirectly and broadly, as being integral component of the right to an adequate standard of living. This article stipulates a general entitlement to an adequate standard of living, by way of recognizing -albeit at an abstract level- guarantees for health and well-being as well as a link to other rights, such as the rights to food and housing.¹⁹ As such, this provision alludes that the enjoyment of the right to an adequate standard of living

¹⁵ See for a critical view of WHO policies, e.g., B.M. Meier, ‘The World Health Organization, the evolution of human rights, and the failure to achieve Health for All’ in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 163-183.

¹⁶ See, J. Morsink, *The Universal Declaration of Human Rights: Origins, Drafting and Intent*, Philadelphia: University of Pennsylvania Press 1999. Note by way of background that 48 States voted in favor and 8 States abstained (p. 21).

¹⁷ UDHR, adopted on 10 December 1948, by G.A. Res. 217A (III), UN Doc. A/810.

¹⁸ *Ibidem supra* note 16.

¹⁹ A. Eide & W. Barth Eide, ‘Article 25’, in: G. Alfredsson & A. Eide (eds.), *The Universal Declaration of Human Rights: A Common Standard of Achievement*, The Hague/Boston/London: Martinus Nijhoff publishers 1999, pp. 523-550, pp. 523-524.

requires, as a minimum, that every individual shall enjoy the necessary rights, such as adequate food, clothing, housing and the necessary conditions of medical care.²⁰

Importantly, the UDHR does not impose legally binding obligations on States. Even so, the UDHR has been regarded as the cornerstone of the human rights movement. Some commentators argue that the UDHR is not a ‘mere’ statement of principle, but it has obtained growing legal force through customary law.²¹ Henry Steiner, for example, notes that ‘No other document has so caught the historical moment, achieved the same moral and rhetorical force, or exerted as much influence on the movement as a whole (...) bore a more radical message than many of its framers perhaps recognised ... proceeded to work its subversive path through many rooted doctrines of international law, forever changing the discourse of international relations on issues vital to human decency and peace.’²²

Nonetheless, not being the UDHR a legal document involving legal state obligations, the UN adopted two Covenants to elaborate its provisions and transform them in legally binding norms. These Covenants were the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These human rights instruments together with the UDHR are known as the International Bill of Human Rights.²³ Interestingly, in literature, it is argued that the decision to draft two separate Covenants, namely the ICCPR and the ICESCR, was, *inter alia*, a reflection of the unwillingness of some western States to be parties to a single Covenant covering both CP rights and ESC rights, primarily on the basis of implementation reasons.²⁴

²⁰ Ibid.

²¹ P.G. Lauren, *The Evolution of International Human Rights: Visions Seen* (2nd ed.), Philadelphia: University of Pennsylvania Press 2003, p. 232; H. Hannum, ‘The Status and Future of the Customary International Law of Human Rights: The Status of the Universal Declaration of Human Rights in National and International Law’, *Georgia Journal of International and Comparative Law* 1995, Volume 25, Number 2, pp. 287-398; H.P. Hestermeyer, ‘Access to Medication as a Human Right’, in: Ar. Von Bogdandy & R. Wolfrum (ed.), *Max Planck Yearbook of United Nations Law* Volume 8, Leiden: Martinus Nijhoff Publishers 2004, pp. 101-180, p. 156.

²² H.J. Steiner, P. Alston, & R. Goodman, *International Human Rights in Context- Law, Politics and Morals* (3rd ed.) Oxford: Oxford University Press 2008, p. 136.

²³ M.A. Baderin & R. McCorquodale, ‘The International Covenant on Economic, Social and Cultural Rights: Forty Years of Development’, in: M.A. Baderin & R. McCorquodale (eds.), *Economic, Social and Cultural Rights in Action*, Oxford: Oxford University Press 2007, pp. 3-26, pp. 4-9.

²⁴ Ibid.; See, e.g., A. Eide, ‘Economic, Social and Cultural Rights as Human Rights’, in: A. Eide, C. Krause and A. Rosas (eds) *Economic, Social and Cultural Rights: A Textbook*, 2nd

3 Article 12 ICESCR

Despite the objections to the legally binding nature and meaning of economic and social rights found in literature²⁵, the ICESCR (1966) is the first international legal source of ESC rights that recognizes the right to health under Article 12.²⁶ In fact, Article 12 ICESCR adopts the affirmative definition of health (i.e., *the highest attainable standard of physical and mental health*) and the enumeration of exemplary steps required by States parties for realizing the right to health within their jurisdiction.²⁷ Nonetheless, Article 12 ICESCR (initially Article 13, eventually Article 12) was subjected to several changes until its final adoption by the UN General Assembly.²⁸ Indeed, the first paragraph of the Article under discussion initially provided that ‘the States parties to the Covenant, realizing that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, recognize the right of everyone to the enjoyment of the highest attainable standard of health’.²⁹ However, the General Assembly’s Third Committee decided not to include this definition of health into the final text,

Ed., Dordrecht/ Boston/London: Martinus Nijhoff Publishers 2001, pp. 9-28, pp. 10-11; Of note, as it goes well beyond the scope of this chapter to elaborate on this issue, for a discussion concerning conflicting arguments during the drafting process lasting nearly twenty years (1949-1966), see Annotations to the Text of the Draft International Covenant on Human Rights, UN Doc. A/2929, 1 July 1955, Ch. II, p. 7; M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia 2003, pp. 116-118 (citing relevant studies).

²⁵ As regards to the objections expressed in literature, see, e.g., M. Scheinin, ‘Economic and Social Rights as Legal Rights’ in: A. Eide, C. Krause & A. Rosas (eds.) *Economic, Social and Cultural Rights: A Textbook*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 29-54, pp. 29-31 (citing relevant studies); M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, pp. 352-353.

²⁶ International Covenant on Economic, Social and Cultural Rights (ICESCR) 16 December 1966, entered into force 3 January 1976, 993 UNTS 3. As at 30 June 2016, 164 States were parties to the ICESCR (among which Greece – see Annex 2) and as such the ICESCR holds almost universal ratification; See, e.g., S. Leckie & A. Gallagher, *Economic, Social and Cultural Rights: A Legal Resource Guide*, Philadelphia: University of Pennsylvania Press 2006, p. xiv and pp. 5-14; *Ibidem supra* note 2, p. 9.

²⁷ *Ibid.*

²⁸ *Ibidem supra* note 11, B.C.A. Toebes 1999, pp. 41-52 (provides an overview of the drafting history of the right to health in the ICESCR).

²⁹ *Ibid.*; See also, *Annotations on the text of the draft International Covenants on Human Rights*, UN Doc. A/2929, 1 July 1955, Ch. VIII, p. 111.

due to disagreement.³⁰ As such, the final wording of Article 12 § 1 ICESCR provides that: ‘States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.³¹ Apart from the reference to physical and mental health, the term ‘health’ is not further defined. There is no explicit reference to social well-being in ICESCR such as is found in the WHO definition. Note also that the implementation nature of Article 12 § 1 ICESCR is qualified by the general approach of the ICESCR embedded in its Article 2 § 1. Simply put, States parties are obliged to progressively realize the right to health to the maximum of their available resources (see sections 3.4 and 4.2.1).³²

Another matter of dispute during the drafting of Article 12 ICESCR was whether or not to specify in the text steps required by States for realizing the right to health. Some participants argued that there was no need to make a reference to definite steps in the text, whereas others were in favor of using an explicit and concrete language as to the state obligations arising from the right to health.³³ Hence, the final wording of Article 12 § 2 ICESCR sets out, in a non-exhaustive way, a list of four specific areas in which States are required to take steps in order to achieve the full realization of this right. This list includes: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.³⁴ The above steps generally illustrate that the right to health is not only curative and preventive, but also requires the enhancement of conditions that promote the health of individuals. All in all, this exemplary enumeration of steps indicates the obligations of the States -the primary duty holders-, towards the individual-the rights holder.

Nonetheless, altogether these state obligations under Article 12 ICESCR read in conjunction with Article 2 § 1 ICESCR broadly formulate the right to health, in that not only they do not concretely define its meaning and its particular elements, but also they do not include an exhaustive enumeration of principal conditions

³⁰ Ibid., §§ 33 & 34 (Art.13).

³¹ Ibidem supra note 26.

³² Ibidem supra note 26, Article 2 § 1 ICESCR.

³³ Ibidem supra note 29, § 35(Art.13); See generally, H.D.C. Roscam Abbing, *International Organizations in Europe and the right to health care*, Deventer: Kluwer 1979, pp. 64-77; Ibidem supra note 11, pp. 41-52.

³⁴ Ibidem supra note 26.

required by States for its enjoyment by every individual. Given the lack of clarity about the scope of the right to health and the nature of the ensuing state obligations several objections as to its formulation under Article 12 ICESCR have been expressed by academic commentators. For example, generally speaking of the ICESCR Craven opined that the rights recognised in the Covenant 'are stated in an excessively broad and general manner'.³⁵ Meanwhile, more specifically in literature it is maintained that the right to health as enshrined in Article 12 ICESCR has been misconstrued as an aspirational rather than an enforceable individual right.³⁶ Thereto, the view taken here is that given also the high level of abstraction that characterizes Article 12 ICESCR, an interpretation must be attempted by other sources in order to achieve clarity as to the content of the right to health. As will be mentioned below, an authoritative -albeit expansive- interpretation of the meaning of the broad-based right to health in Article 12 ICESCR and of the nature of the ensuing state obligations is provided by the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment (GC) No. 14 (see section 2.2.4 and chapter 3).³⁷

2.2.2. OTHER UN TREATIES

Over the years a number of other subsequent UN legally binding human rights documents have focused on the right to health of specific populations groups, including children, women, racial minorities, migrant workers and persons with disabilities. Such treaties include the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), the International Convention on the Elimination of All forms of Racial Discrimination (ICERD), the International Convention on the Protection of the

³⁵ Ibidem supra note 25, M.C.R. Craven 1995, p. 353.

³⁶ See, e.g., L. Forman, 'What future for the minimum core? Contextualizing the implications of South African socioeconomic rights jurisprudence for the international human rights to health' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 62-80, p. 66; T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, Volume 30, Issue 6, pp. 643-662; Ibidem supra note 25, M. Scheinin 2001 (citing relevant studies).

³⁷ UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000; Note also that as regards to the right to sexual and reproductive health, an integral component of the right to health (§1), the CESCR has adopted General Comment No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016.

Rights of All Migrant Workers and Members of Their Families (MWC) and the Convention on the Rights of Persons with Disabilities (CRPD). Each of these conventions expanded the human rights protection applicable to these specific groups beyond those offered under ICCPR and ICESCR. Additionally, each aforementioned convention aims to contribute to the normative development of human rights, in general and the right to health *in concreto* within its specific contexts by defining and expanding the contours of these rights (see below).

1 Article 24 CRC

The CRC (1989) under Article 24 stipulates the right to health of the child. In particular, Article 24 § 1 CRC provides that ‘States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.’³⁸ As such, Article 24 § 1 CRC entails entitlements to both health care and the underlying determinants of health. By way of background, it is noteworthy that when looking at the *travaux préparatoires* of the CRC, it is discerned that the wording of the phrase ‘the enjoyment of the highest attainable standard of health’ in Article 24 § 1 was inspired by the language of Article 12 § 1 ICESCR.³⁹ It can also be observed that the specific reference of the provision ‘to facilities for the treatment of illness and rehabilitation of health’, which is also found in Article 23 CRC (disabled children), is in conformity with the policies of the WHO.⁴⁰ Furthermore, under Article 24 § 1 States parties have an obligation ‘to ensure that no child is deprived of his or her right of access to such health care services’.⁴¹ Meanwhile, it appears that the wording of this provision, namely the inclusion of the term ‘no child is deprived’, imposes a relatively strong state duty in that it requires health care to be available and accessible to all children.⁴² During the

³⁸ Convention on the Rights of the Child, New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3. As at 30 June 2016, 196 States were parties to the CRC among which Greece (see Annex 2).

³⁹ S. Detrick (ed.), *The United Nations Convention on the Rights of the Child. A Guide to the “Travaux Préparatoires”*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 1992, pp. 343-359; S. Detrick, *A Commentary on the United Nations Convention on the rights of the child*, The Hague: Kluwer Law International and Martinus Nijhoff Publishers 1999, p. 402.

⁴⁰ *Ibid.*, S. Detrick 1999, pp. 399 & 404.

⁴¹ *Ibidem supra* note 38.

⁴² A. Eide & W. Barth Eide, ‘Article 24. The Right to Health’ in: A. Alen, J. Vande Lanotte,

course of the drafting of Article 24 the term ‘no child shall be deprived of his or her right of such health care facilities’ was decided as a compromise between conflicting views on whether State parties should be required to provide health care free of charge.⁴³

The second paragraph of Article 24 CRC contains a number of broad-based measures with a main focus on health care that States should take with a view to pursuing the full implementation of the right to health of the child. Particularly, such measures include the reduction of infant and child mortality (2-a), the provision of necessary medical assistance and health care for all children with an emphasis on primary health care (2-b), pre- and post-natal health care for mothers (2-d), to combat disease and malnutrition, including within the framework of primary healthcare (2-c), to enable children and their families to have access to education, basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene, environmental sanitation, prevention of accidents (2-e) and preventive health care, family planning education (2-f). Further, Article 24 § 3 obligates States ‘to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children’.⁴⁴ Moreover, Article 24 § 4 places an emphasis on the role of international co-operation in relation to the right to health of the child by encouraging States to engage in such co-operation with a view to progressively realize the right.⁴⁵

The list of measures required by States parties under Article 24 § 2 is in some cases similar to that imposed under Article 12 § 2 ICESCR, such as the reduction of infant mortality, whereas in other cases Article 24 § 2 CRC advances the state measures under Article 12 § 2 ICESCR. Areas such as access to health-related information, education and family planning that are adopted in Article 24 § 2 CRC are not addressed under Article 12 § 2 ICESCR (see section 2.2.1). Additionally, Article 24 § 2, § 3 and § 4 CRC contains a number of new provisions, namely, the provision on traditional practices prejudicial to the health of children and the provision of primary health care and facilities for the rehabilitation of health, which highly reflect the policies of WHO, as well as the need for international co-operation for realizing the right to health.⁴⁶ On the basis of the above, we may conclude that

E. Verhellen, F. Ang, E. Berghmans & M. Verheyde (eds.), *A Commentary on the United Nations Convention on the Rights of the Child*, Leiden: Martinus Nijhoff Publishers 2006, p. 11.

⁴³ *Ibid.*, p. 12; *Ibidem supra* note 39, S. Detrick 1999, p. 403.

⁴⁴ *Ibidem supra* note 38, Article 24 § 3 CRC.

⁴⁵ *Ibidem supra* note 38.

⁴⁶ *Ibidem supra* note 39, S. Detrick 1999, pp. 399 & 404-406; Of note, the primary health

Article 24 CRC provides a more detailed and comprehensive provision than Article 12 ICESCR and as such Article 24 CRC can offer more protection to children than Article 12 ICESCR. Last but not least, it is notable that the implementation nature of Article 24 CRC is informed by the broad obligation embedded in Article 4 CRC, namely the state obligation to take ‘all appropriate measures’ to the maximum extent of a State’s available resources (see section 4.2.2).

In literature, meanwhile, Article 24 CRC has been described as the most specific and expansive provision on the right to health in international human rights law.⁴⁷ For example, for Fox and Young⁴⁸, Article 24 CRC is international law’s ‘most elaborate and specific such guarantee’. On the other hand, there are scholars who hold different views as to the formulation of the right to health under Article 24 CRC. It is maintained, for instance, that altogether the state obligations under Article 24 CRC provide a broad framework of measures that requires further interpretation when it comes to be applied worldwide given the different levels of development and children’s health needs among countries.⁴⁹ Indeed, the wording of Article 24 CRC is rather general in nature and needs to be qualified in practice when interpreted and applied. Thereto, this interpretation must result to the provision of clarity as to the nature of the right to health of children and the associated state obligations under Article 24 CRC, while at the same time it must be cognizant of the realities of daily lives of children and their families.⁵⁰ As will be mentioned in section 2.2.4, an elaboration of the meaning of right to health of the child

approach was defined in the Declaration of Alma-Ata and reinforced by the World Health Assembly (Doc. A62/8); Note that the concept of primary health care was also embraced in the articulation of the right to health in Article 10 (2) (a) of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (see section 2.3.2) and in Article 14 (2) (b) of the African Charter on the Rights and Welfare of the Child (see section 2.3.3).

⁴⁷ Ibidem supra note 39, S. Detrick 1999, p. 399; See, e.g., J.E. Doek, ‘Children and Their Right to Enjoy Health: A Brief Report on the Monitoring Activities of the Committee on the Rights of the Child’, *Health and Human Rights*, 5(2), pp. 155-162, p. 156; E.D. Kinney, ‘The Human Right to Health Care’ *Rutgers Law Review* 2008, Volume 60, Issue 2, pp. 335-379.

⁴⁸ S.J. Fox & D. Young ‘International Protection of Children’s Right to Health: the Medical Screening of Newborns’, *Boston College Third World Law Journal* 1991, Volume 11, Issue 1, pp. 1-43, p. 42.

⁴⁹ See, e.g., S.I. Spronk-van der Meer, *The Right to Health of the Child: An Analytical Exploration of the International Normative Framework*, Antwerp: Intersentia 2014, pp. 44-46 (citing relevant studies).

⁵⁰ Ibid.

enshrined in Article 24 CRC is provided by the Committee on the Rights of the Child (CRC Committee) in its General Comment (GC) No. 15.⁵¹

2 Article 12 CEDAW

The CEDAW (1979) under respective provisions pays particular attention to women's health and well-being. States parties under Article 12 CEDAW are required to '(1) ... take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to *family planning*. (2) ... ensure to women appropriate services in connection with *pregnancy, confinement and the post-natal period*, granting free services where necessary, as well as *adequate nutrition during pregnancy and lactation*' [emphasis added].⁵² CEDAW in Article 12 § 1 does not mandate States parties to ensure equal access to health care services for women at a relatively general and abstract level, but rather particularly points out that 'health care services' encompass those related to family planning.⁵³ Moreover, Article 12 § 1 guarantees access to health care services by taking into account at the same time the prohibition against discrimination, while Article 12 § 2 considers women's right to health from a gender perspective by relating this right to maternal health care.⁵⁴ As such, it must be recognized that this provision tends to offer some specific content to the notion of the right to health of women.

Meanwhile, Article 12 CEDAW should be read in conjunction with General Recommendation No. 24, adopted by the CEDAW Committee in 1999. Although this document is not legally binding, it is an authoritative source that tends to provide further clarification with respect to state obligations under Article 12 CEDAW and address measures to eliminate discrimination against women with a view to realizing the right of women to health. Accordingly, States are required to eliminate discrimination against women in their access to healthcare services,

⁵¹ UN CRC Committee, General Comment No. 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, UN Doc. CRC/C/GC/15, March 2013.

⁵² CEDAW, adopted by G.A. Resolution 34/180 of 18 December 1979, entered into force 3 September 1981, UN Doc. A/34/46. As at 30 June 2016, 189 States were parties to the CEDAW, among which Greece (see Annex 2).

⁵³ *Ibidem supra* note 11, B.C.A. Toebes 1999, pp. 52-55 (provides a brief overview of the drafting history of the right to health in the CEDAW).

⁵⁴ See generally, A. Hendriks, 'The Right to Health. Promotion and Protection of Women's Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women's Convention' *The American University Law Review* 1995, Volume 44, pp. 1123-1144.

throughout the life cycle, specifically in the areas of family planning, pregnancy, confinement and during the post-natal period.⁵⁵ In particular, the measures required by States encompass not only the provision of equal access to quality healthcare for women, but also the respect for confidentiality and for informed consent, the provision of proper health information and health education (information and counselling on family planning).⁵⁶ Nevertheless, the CEDAW Committee in its General Recommendation No. 24 does not further elaborate on the meaning of the state obligation to grant ‘free services where necessary’ by way of identifying the circumstances under which this obligation must be satisfied. Instead, the Committee adopts in its Recommendation a broad position by stating that ‘it is the duty of States parties to ensure women’s right to *safe motherhood and emergency obstetric services* and they should allocate to these services the *maximum extent of available resources*’ [emphasis added].⁵⁷

In the spirit of Article 12 CEDAW, it is worth noting that Articles 14 § 2 (b) and 10 (h) of the Convention also stipulate that States are required to ensure to women on the basis of equality between men and women the right to access ‘adequate health care facilities, including information, counseling and services in family planning’ and ‘specific educational information to help ensure the health and well-being of families’ respectively.⁵⁸ Additionally, it is notable that Article 11 § 1 (f) of the Convention provides in the context of employment for ‘the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction’.⁵⁹ Here, the Convention employs a new term ‘protection of health’ contrary to the wording of other international documents, such as Articles 12 ICESCR and 24 CRC which use the term ‘the right to the enjoyment of the highest attainable standard of health’. The use of the term ‘protection’ alludes to certain undertakings on the part of the States for creating good health conditions for women or at least refraining from acts or omissions detrimental to women’s health (see section 3.3).⁶⁰

⁵⁵ UN CEDAW Committee, *General Recommendation No. 24: Women and Health*, UN Doc. A/54/38 1999, § 2.

⁵⁶ *Ibid.*, § 12(d), 20, 22 & 23.

⁵⁷ *Ibid.*, § 27.

⁵⁸ *Ibidem supra* note 52.

⁵⁹ *Ibid.*

⁶⁰ For a definition of the term ‘health protection’, see, e.g., World Health Organization, *Glossary of Terms*, Geneva: WHO 1984, § 30. < <http://www.who.int>>; *Ibidem supra* note 11, B.C.A. Toebees 1999, p. 247; A. Hendriks, ‘The Right to Health in National and International Jurisprudence’, *European Journal of Health Law* 1998, 5, pp. 389-408, p. 394.

Last but not least, in literature it has been commented that ‘given the importance the Women’s Convention attaches to nondiscrimination and the elimination of female stereotyped roles, it is easier to understand the inherent meaning of Article 12’.⁶¹ This seems to be true. On the other hand, we should also point out that this is not to suggest that the CEDAW has a limited scope, in that the Convention solely focuses on the principles of non-discrimination and equality without setting forth any health-related state obligation. Instead, the CEDAW primarily under Article 12 requires the adjustment (i.e., incorporation) of these principles in order to eradicate and prohibit gender discrimination both in and outside the healthcare sector. Nonetheless, Article 12 CEDAW has a more limited scope than Article 12 ICESCR, which also includes access to the underlying determinants of health, such as adequate nutrition, sanitation, housing, etc. Toebe, for instance, pointedly argues that this must be viewed as the drafters’ intention to focus only on those health-related areas where women require additional protection.⁶²

3 Article 5(e)(iv) ICERD

In general, the ICERD⁶³ (1965) strengthens the non-discrimination and equality principles with respect to race. In particular, Article 5 ICERD contains a specific list of rights, among which the right to health, in which discrimination is not allowed. The ICERD expressed the right to health in Article 5 (e)(iv) in the sense that State Parties are to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services. As such, under this Article the reference to health as a right is limited only to services and actions related to the elimination of discrimination in relation to public health rather than to the right to health as formulated in Article 12 ICESCR.⁶⁴

Indeed, the precise nature of the obligation under Article 5 ICERD is pointedly

⁶¹ Ibidem supra note 54, A. Hendriks 1995, p. 1141.

⁶² Ibidem supra note 11, B.C.A. Toebe 1999, p. 55.

⁶³ ICERD, GA Resolution 2106 (XX) of 21 December 1965, entered into force 4 January 1969, 660 UNTS 195. As at 30 June 2016, 177 States were parties to the ICERD, among which Greece (see Annex 2).

⁶⁴ See, also, UN CERD, General Recommendation No. 20 on Article 5, March 1996, UN Doc. A/51/18, annex VIII, reprinted UN Doc. HRI/GEN/1/Rev.6 (2003), § 1. The Committee observes that Article 5 ‘apart from requiring a guarantee that the exercise of human rights shall be free from racial discrimination, does not itself create civil, political, economic, social or cultural rights, but assumes the existence and recognition of these rights. The Convention obliges States to prohibit and eliminate racial discrimination in the enjoyment of such human rights’.

acknowledged in the Initial Report to the CERD submitted by the United States of America (USA). The USA maintained the position that Article 5 ICERD does not lay down any substantive health-related state obligation, rather focuses on eliminating discrimination in all its forms.⁶⁵ In particular, the respective State stressed that ‘article 5 does not affirmatively require States Parties to provide or to ensure observance of each of the listed rights themselves, but rather to prohibit discrimination in the enjoyment of those rights to the extent they are provided by domestic law’.⁶⁶

4 Articles 28, 43 and 45 MWC

Contrary to other international documents (e.g., Article 12 ICESCR), the MWC (1990) contains state obligations solely in the area of access to health care for both documented and non-documented migrant workers and the members of their families under respective provisions.⁶⁷ In particular, Articles 28, 43 and 45 MWC grant an equal right to healthcare services to documented migrant workers and the members of their families. Nevertheless, Article 28 is also dedicated to protecting non-documented migrants and their families from discrimination in accessing health care services and facilities. Specifically, Article 28 clearly underlines the right to equal treatment with regard to access to health services for non-documented migrant workers and members of their families in terms only of emergency medical treatment. Although MWC seems to be the only international Convention explicitly guaranteeing a right to medical assistance to non-documented migrants, it does however ensure access to health care for non-documented migrants in a restrictive manner. Put simply, besides access to emergency medical treatment, it does not cover access to other forms of medical treatment (e.g., preventive care, reproductive care etc.) for this population group.

Last but not least, it should be noted that the scope of the Convention is limited, as the number of ratifications to this Convention is still relatively slow. This Convention has still not been ratified by the Member States of the EU, such as

⁶⁵ Initial Report of the United States of America to the Committee on the Elimination of Racial Discrimination, UN Doc CERD/C/351/Add.1, 10 October 2000, § 297.

⁶⁶ *Ibid.*, § 298.

⁶⁷ MWC, adopted in New York, 18 December 1990, entered into force 1 July 2003, 2220 UNTS 3; Article 5 MWC defines the terms documented (or in a regular situation) and non-documented (or in an irregular situation) migrants workers on the basis of whether or not these individuals obtain an authorization to enter, to stay or to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which it is a party.

Greece, as well as by the majority of the countries worldwide.⁶⁸ Considering the slow ratification of the MWC, one may agree with the argument that this reflects ‘a broader general resistance to recognition of application of human rights standards to migrants, particularly undocumented migrants’.⁶⁹

5 Article 25 CRPD

Article 25 CRPD (2006) recognizes the right of persons with disabilities to ‘the enjoyment of the highest attainable standard of health without discrimination on the basis of disability...’ as well as imposes on States parties specific obligations in order to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.⁷⁰ In other words, the CRPD under Article 25 highlights the significance of the enjoyment of the right to health on an equal basis and without discrimination on the grounds of disability. In particular, under Article 25 (2), States are required to provide access to health services on an equal basis with others, including in the area of sexual and reproductive health and public health programmes (2-a), to provide health services targeted to the needs of persons with disabilities and services designed to minimize and prevent further disabilities (2-b), to provide health services close, insofar as is possible, to people’s own communities, including in rural areas (2-c), to ensure that health professionals provide equal quality care on the basis of free and informed consent by pursuing certain actions (2-d), to prohibit discrimination in the provision of health and life insurance (2-e) and in the provision of health care or health services or food and fluids on the basis of disability (2-f).⁷¹

The CRPD recognizes the right ‘to the enjoyment of the highest attainable standard of health’ in Article 25 in line with the language and broad character of Article 12 ICESCR, placing, however, an explicit emphasis on the principles of equality and non-discrimination on the basis of disability. In literature it is argued that altogether the state obligations under Article 25 CRPD constitute the longest and most programmatic formulation of the right to health in international human rights law.⁷² Indeed, the general formulation of Article 25 CRPD, namely the broad

⁶⁸ As at 30 June 2016, only 48 States were parties to this Convention.

⁶⁹ P.A. Taran, ‘Human Rights of Migrants: Challenges of the New Decade’ *International Migration* 2000, Volume 38, Issue 6, pp. 7-51, p. 18.

⁷⁰ CRPD, adopted in New York, 13 December 2006, entered into force 3 May 2008, 2515 UNTS 3, UN Doc. A/RES/61/106. As at 30 June 2016, 166 States were parties to the CRPD, among which Greece (see Annex 2).

⁷¹ *Ibid.*

⁷² See, e.g., A. Hendriks & O. Lewis, ‘Disability’ in: Y. Jolly & B.M. Knoppers (eds) *Routledge*

wording and character of the right to health and its programmatic duties, largely alludes to the aforementioned argument. At the same time, in reaction, one might argue that Article 25 CRPD does not merely impose programmatic obligations but rather it tends to provide supplementary protection to a specific population group beyond those offered under Article 12 ICESCR. Specifically, this provision further informs the nature of the right to health in relation to its enjoyment by persons with disabilities as well as imposes more duties on States targeted to the health needs of this particular group that were not included at the time of the drafting of Article 12 ICESCR.

2.2.3. OTHER KEY SOURCES

In addition to human rights law, there are several other international documents (i.e., declarations, recommendations, plans, and regulations) that provide an interpretation of and/or are related to the right to health and as such these documents can also frame the standards and principles that national health legislation and policies should reflect.⁷³

Since the WHO Constitution and ICESCR, the right to health has been addressed in several WHO Declarations, primarily in the Declaration of Alma-Ata and the World Health Declaration. The International Conference on Primary Health Care that was sponsored by the WHO and UNICEF resulted in the adoption of the 1978 Declaration of Alma-Ata on Primary Health Care, which proclaimed the right to health in its § I and drew attention to primary health care as a way to realize this right (see also section 3.4).⁷⁴ The Declaration underlined that primary health care at least encompasses education on prevailing health problems and the methods on preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against major infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.⁷⁵ It also affirmed the responsibility of States to provide for the health of their populations ‘which can be fulfilled only by the provision of adequate

Handbook of Medical Law and Ethics, London and New York: Routledge 2014, pp. 78-97, p. 89.

⁷³ See generally, e.g., J. Asher, *The right to health: a resource manual for NGOs*, London: Commonwealth Medical Trust 2004.

⁷⁴ §§ I and VI of Declaration of Alma-Ata; Note that the UN General Assembly endorsed the 1978 Declaration of Alma-Ata on Primary Health Care by Res 34/43 of 19 November 1979.

⁷⁵ § VII (3) of the Declaration, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

health and social measures' and by 'making fullest use' of (internal and external) resources to this end.⁷⁶ Yet, despite the Declaration's notable approach to (primary) health and its underlying determinants as well as to the progressive development of comprehensive health care for all, especially for those most in need,⁷⁷ in literature it is commented that WHO's past insufficient commitment to human rights impeded its effective implementation and finally led to its abandonment by WHO.⁷⁸

The commitment to the principle embedded in WHO Constitution 'that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' was reaffirmed by the World Health Assembly in 1998 in the 'World Health Declaration'.⁷⁹ It generally acknowledged the need to give effect to the 'Health-for-All policy for the twenty first century' through the implementation of relevant regional and national policies, without however identifying concrete measures to this aim. At the same time, the WHA is notable in its emphasis on the significance of reducing social and economic inequities in improving the health of the whole population and in particular to consider 'those most in need, burdened by ill-health, receiving inadequate health care or affected by poverty'.⁸⁰

Meanwhile, beyond WHO declarations, since the early 1990s a series of other international conferences held under the auspices of the UN elaborated to a degree upon the meaning of health as a right, involving the extent of State's accountability, the position of vulnerable groups (e.g., women, children) as well as its connection to other rights.⁸¹ The most notable in articulating health as a right were: the 1993 World Conference in Vienna, the 1994 International Conference on Population and Development (ICPD), the 1995 Fourth World Conference on Women (FWCW), the 1995 World Summit for Social Development (WSSD) and the 2000 Millennium Development Summit.

In June 1993 a World Conference on Human Rights was held in Vienna resulting in the adoption of the Vienna Declaration.⁸² Most importantly, the Declaration

⁷⁶ Ibid., §§ V, VII(5), VIII and X.

⁷⁷ Ibid., §§ I, V, VII (3) and (6).

⁷⁸ Ibidem supra note 15, B.M. Meier 2010, p. 178.

⁷⁹ WHO, Fifty-first World Health Assembly, WHA Doc. 51.7, 16 May 1998, Annex § I.

⁸⁰ Ibid., Annex § II.

⁸¹ See, e.g., S. Gruskin & D. Tarantola, 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (eds), *Perspectives on health and human rights*, New York and London: Routledge 2005, pp. 3-57, pp. 9-10; Ibidem supra note 11, B.C.A. Toebes 1999, pp. 74-76.

⁸² World Conference on Human Rights, 14-25 June 1993, Vienna Declaration and Programme of Action, UN Doc. A/CONF.157/23, 12 July 1993.

emphasized the indivisibility and interrelatedness of all human rights, requiring all human rights (i.e., CP and ESC rights) to be treated ‘in a fair and equal manner on the same footing, and with the same emphasis’.⁸³ Notably, the formulation of health as a right figures in several paragraphs of the Declaration. For example, at § 41 (section I) and §§ 47-48 (section II) the right to health of women and children is mentioned, respectively. Another health-related reference is found in §§ 11, 18 (medical care of women), 24 (health of vulnerable groups, such as migrant workers) of the Declaration, where health is articulated as a State’s duty.⁸⁴

Moreover, from 5 to 13 September 1994 an intergovernmental conference on population and development was held in Cairo, namely the ICPD.⁸⁵ After prolonged discussions and debates between participants, the Cairo Conference resulted in the consensus, *inter alia*, on two health goals to be achieved over the next 2 decades: the reduction of infant, child and maternal mortality⁸⁶; and the provision of universal access to a full range of reproductive health-care services, including family planning.⁸⁷ At the same time, reproductive health was placed within the human rights framework, in that it was explicitly acknowledged that ‘reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health’.⁸⁸

⁸³ Ibid., § 5, section I.

⁸⁴ Ibid., section I.

⁸⁵ Programme of Action of the International Conference on Population and Development, adopted in 1994 by 179 States (note that in 1999 the UN General Assembly adopted the Key Actions for its further implementation), UN Doc. A/CONF.171/13/Rev.1.

⁸⁶ Ibid., sections 1.12 and 1.14; See also, *inter alia*, sections 8.12, 8.15, 8.16 (child survival and health) and 8.20, 8.21, 8.22 (women’s health and safe motherhood) of Programme of Action; See, e.g., J. Gottschalk, ‘Cairo to Beijing: Disaster Averted’, *Social Justice* 1995, Volume 22, Number 4, pp. 89-96, p. 89.

⁸⁷ Ibid., sections 1.12 and 1.14; See also, *inter alia*, sections 7.5, 7.6 (reproductive health) and 7.12 (family planning) of Programme of Action.

⁸⁸ Ibidem supra note 85 section 7.3; See, e.g., L.P. Freedman, ‘Human Rights and the Politics of Risk and Blame. Lessons from the International Reproductive Health Movement’ in: S. Gruskin, M.A. Grodin, G.J. Annas, S.P. Marks (eds), *Perspectives on health and human rights*, New York and London: Routledge 2005, pp. 527-536, p. 532. Freedman stressed that the ICPD ‘marked the formal acceptance at the international level of a new paradigm in which health is intimately tied to rights’.

Further, the FWCW held in Beijing on 4-15 September 1995 resulted in the adoption of the Beijing Declaration which set out five strategic objectives aimed at enhancing women's health status worldwide.⁸⁹ The Beijing Declaration attempted to specify some concrete measures -albeit noncommittal as to the resources required for their implementation- that States should take to promote women's reproductive and sexual health.⁹⁰ Such measures include, *inter alia*, the provision of more accessible, available and affordable primary health care of high quality.⁹¹ Moreover, the Beijing Declaration discerned that 'women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology... A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups'.⁹²

Additionally, in March 1995, the WSSD took place in Copenhagen, where States -after hard-fought discussions- reached a consensus on the need to put people at the centre of development as well as on a number of health-related issues, with particular reference, *inter alia*, to the need to ensure full access to health care for women and children.⁹³ Note by way of background that following the conferences from the nineties, a number of (follow-up) conferences have been organized by the UN to monitor whether the stated goals in their previous plans of action had been accomplished (or not) and to reaffirm their respective commitments.⁹⁴ Meanwhile, in September 2000 at the Millennium Development Summit the

⁸⁹ Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, UN Doc. No. A/CONF. 177/20, Strategic Objectives C.1-C.5, §§ 106 -111.

⁹⁰ *Ibid.*, *inter alia*, §§ 30, 44 and section C, §§ 89-104; *Ibidem supra* note 86, J. Gottschalk 1995, p. 96; Note that the final text of the Beijing Declaration and Platform for Action was adopted by consensus after heated debates as to issues involving women's equality, health, abortion etc. (see, e.g., B. Roberts, 'The Beijing Fourth World Conference on Women', *The Canadian Journal of Sociology* 1996, Volume 21, No. 2, pp. 237-244, p. 240; M. Haslegrave & J. Havard, 'Women's Right to Health and the Beijing Platform for Action: The Retreat from Cairo?', *Health and Human Rights* 1995, Volume 1, No. 4, pp. 461-471.)

⁹¹ *Ibid.*, § 106e.

⁹² *Ibid.*, § 89.

⁹³ World Summit for Social Development 1995, section 35, § c; *Ibidem supra* note 11, B.C.A Toebes 1999, p. 75; *Ibidem supra* note 86, J. Gottschalk 1995, p. 93.

⁹⁴ See, e.g., the commitment to the Beijing Platform for Action was reaffirmed by: Beijing+5 (2000 - UN Doc. A/RES/S-23-3), Beijing+10(2005- UN Doc. E/CN.6/2005/L.1), Beijing+15(2010- UN Doc. E/CN.6/2010/L.1) and Beijing+20(2015 - UN Doc. E/CN.6/2015/L.5); *Ibidem supra* note 73, J. Asher 2004, pp. 90 & 172-173.

international community made another global health-related commitment, reflected in the Millennium Declaration.⁹⁵ The Millennium Declaration identified 8 Millennium Development Goals (MDGs) to be achieved by the year 2015, four of which were clearly related to health: the reduction of infant mortality (Goal 4); the improvement of maternal health (Goal 5); the combat of HIV/AIDS, malaria and other diseases (Goal 6); and ensuring environmental sustainability (i.e., the reduction by half the proportion of people without sustainable access to safe drinking water - Goal 7).⁹⁶ In a general sense, four other of the MDGs, namely Goal 1 (to eradicate extreme poverty and hunger), Goal 2 (to achieve primary education), Goal 3 (to promote gender equality and empower women) and Goal 8 (to develop a global partnership for development) were closely connected to health in that their achievement can influence people's health.⁹⁷

In 2013 the UN General Assembly reaffirmed its commitment to the Millennium Declaration and decided to determine and formulate the post-2015 development agenda, which will build on the foundations laid by the MDGs, fulfill the previous commitments and respond to new challenges.⁹⁸ Indeed, in October 2015 the adoption of the 2030 Agenda for Sustainable Development (the 2030 Agenda) by the international community marked the transition from the MDGs to the Sustainable Development Goals (SDGs).⁹⁹ The 2030 Agenda encompasses 17 goals, one of which is clearly related to health: to ensure healthy lives and promote well-being for all at all ages (Goal 3) and is linked with nine targets, which involve, *inter alia*, the reduction of maternal and child mortality, the achievement of universal health coverage as well as the reduction and management of global and national health risks.¹⁰⁰ At the same time, a considerable number of other goals includes health-related commitments, such as Goal 1 (to eradicate poverty), Goal 2 (to achieve food security and improved nutrition), Goal 4 (to ensure inclusive

⁹⁵ UN Millennium Declaration Resolution, UN GA Res. 55/2 §§ 11-23, UN Doc. A/55/L.2, 8 September 2000; E.D. Kinney, 'Realizing the international human right to health: the challenge of for-profit health care', *West Virginia Law Review* 2010, Volume 113, pp. 49-66, p. 55.

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Outcome document of the special event to follow up efforts made towards achieving the Millennium Development Goals issued by the UN General Assembly, UN Doc. A/68/L.4, 1 October 2013, §§ 16-17.

⁹⁹ *Transforming our world: the 2030 Agenda for Sustainable Development*, GA Res 70/1, UN Doc. A/RES/70/1, 21 October 2015.

¹⁰⁰ Ibid., pp. 14 and 16-17.

and equitable quality education), Goal 6 (to ensure availability and sustainable management of water and sanitation) and Goal 13 (to combat climate change and its impacts).¹⁰¹ Meanwhile, in a general sense the 2030 Agenda involves a commitment ‘to be implemented in a manner that it is consistent with the rights and obligations of States under international law’.¹⁰² Put simply, as regards to the right to health this statement indicates a commitment of the SDGs to the effective realization of this right in the context of the policies and programmes on these Goals, even though the 2030 Agenda does not explicitly address health as a right.

Last but not least, WHO, the core international and intergovernmental health organization can play an instrumental role in the field of health and human rights, primarily in the protection of the right to health of every individual by its engagement with the promotion and protection of public health.¹⁰³ In 2005 WHO adopted the International Health Regulations (IHR) in order to respond to ‘exponential increase in international travel and trade, and emergence and reemergence of international disease threats and other health risks’.¹⁰⁴ The purpose and scope of these binding regulations are ‘to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade’.¹⁰⁵ Importantly, Article

¹⁰¹ Ibid., pp. 14-15, 17-19 and 23; Note that the impact of climate change on health is addressed in a binding manner in the Paris Agreement, particularly in its preamble, (see FCCC/CP/2015/L.9/Rev.1, 12 December 2015 and FCCC/CP/2015/10/Add.1, 29 January 2016), adopted by the Conference of the Parties to the United Nations Framework Convention on Climate Change on its 21st session on 12 December 2015 (also called COP21). The Conference was held in Paris from 30 November to 13 December 2015. The Agreement is opened for signature (see Article 20§1 of the Agreement) and has not yet entered into force (see Article 21§1 of the Agreement). As at 30 June 2016, 19 States were parties to the Paris Agreement.

¹⁰² Ibid., § 18.

¹⁰³ Ibidem infra note 110, GC No. 14, § 63; See also, J. Rothmar Hermann & B. Toebe, ‘The European Union and Health and Human Rights’ in: B. Toebe, M. Hartley, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 51-79, p. 60.

¹⁰⁴ WHO, *International Health Regulations 2005- 2nd ed.*, Geneva: World Health Organization 2008. Available at <<http://www.who.int/ihr/9789241596664/en/>>. Note that the 2005 IHR, which entered into force on 15 June 2007, are a new version of 1969 Regulations and 196 States are parties to the regulations, among which Greece – automatically as a WHO Member State (status as of April 2013). In fact, Greece as a WHO Member State ratified the 2005 IHR by Law 3991/2011, *Official Government Gazette* – ΦΕΚ issue A’ 162/25-07-2011.

¹⁰⁵ Ibid., Article 2 IHR.

3 § 1 of the Regulations provides that their implementation ‘shall be with full respect for the dignity, human rights and fundamental freedoms of persons’.¹⁰⁶ As such, the IHR explicitly refer to human rights as well as acknowledge the significance of human rights protection in case of health emergencies of international concern, such as in the event of international outbreaks of infectious diseases.

In light of the preceding analysis, the series of the international conferences and documents helped in giving recognizable content to health as a right. These developments reflect the general -albeit strictly speaking not ideal- consensus of the international community on the close linkages between health and human rights in human rights treaties and on the need for concrete steps to be taken at international, regional and national levels for effectively realizing the right to health.¹⁰⁷

2.2.4. GENERAL COMMENTS ON THE RIGHT TO HEALTH

In general, a General Comment (henceforth: GC) further elaborates on the content of rights and freedoms embedded in a treaty. A GC is a non-binding document, adopted by a UN treaty monitoring body that seeks to help States in the interpretation of a respective treaty and the implementation of their treaty obligations, as a result. It is an authoritative source which may guide States regarding the scope and nature of their obligations under a respective treaty.¹⁰⁸ In particular, the CESCR and the CRC Committee, the human rights treaty monitoring bodies which oversee the implementation of ICESCR and CRC respectively, have both developed the practice of adopting GCs to clarify the normative framework of the various rights enshrined in ICESCR and CRC, among which the meaning and implications of the right to health.¹⁰⁹

Notably, the CESCR adopted in 2000 GC No. 14 to interpret Article 12 on the right to the highest attainable standard of health (right to health).¹¹⁰ Likewise, the

¹⁰⁶ Ibidem supra note 104.

¹⁰⁷ See for a general approach concerning all human rights supra note 81, S. Gruskin & D. Tarantola 2005, p. 10.

¹⁰⁸ A. Aust, *Handbook of International Law* (2nd ed.), Cambridge: Cambridge University Press 2010, p. 11; Ibidem supra note 21, H.P. Hestermeyer, p. 121.

¹⁰⁹ Website of the Office of the UN High Commissioner for Human Rights, Monitoring Economic, Social and Cultural Rights www.ohchr.org/EN/HRBodies; Note that the CESCR is a structural institution formed not by the international treaty, the ICESCR, but by the Economic and Social Council of the United Nations (ECOSOC), whereas the CRC Committee was formed by an international treaty, the CRC.

¹¹⁰ UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000.; Of note, as regards to the right to sexual

CRC Committee issued in 2013 GC No. 15 to interpret Article 24 on the right to health of the child.¹¹¹ Both GCs attempt to elucidate the normative content of the right to health, as included in Articles 12 ICESCR and 24 CRC, address the issues of implementation and enforcement by delineating the substantive content of the resulting state obligations and the responsibilities of non-State actors.¹¹² In particular, both GCs tend to provide guidelines concerning the nature of State's obligations with respect to the right to health and identify possible violations of it.¹¹³ In interpreting the right to health, both GCs extensively stipulate that the right to health is not a right to be healthy; it contains both freedoms and entitlements.¹¹⁴ The CESCR provides that the right to health is an inclusive right, encompassing not only individual and population healthcare (both preventive and curative), but also attempting to enhance the determinants of health, such as access to safe and potable water, healthy occupational and environmental conditions, and access to health-related education and information, including information on sexual and reproductive health.¹¹⁵ As such, the right to health both encompasses the legal entitlement to health care and to conditions necessary for the realization of the highest attainable standard of health. Similarly, the CRC Committee in GC No. 15 stresses that children not only have a right to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative health care, but also have 'a right to opportunities to survive, grow and develop to their full potential and live in conditions that enable them to attain the highest attainable standard of health through the implementation of programmes that address the underlying determinants of health'.¹¹⁶

Of note, both the CESCR and the CRC Committee broadly underscore -at a relatively high level of abstraction- the importance of international co-operation as part of achieving the right to health as set out in Articles 2 § 1 ICESCR as well as 4 and 24 § 4 CRC respectively, without specifying this obligation in great detail

and reproductive health, an integral component of the right to health (§1), the CESCR adopted General Comment No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016.

¹¹¹ UN CRC Committee, *General Comment No. 15: The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, UN Doc. CRC/C/GC/15, 17 April 2013, §§ 1-4.

¹¹² *Ibidem supra* note 110, GC No. 14, §§ 2, 30-52; *Ibid.*, GC No. 15, §§ 2-4, 71-74 and 75-85.

¹¹³ *Ibid.*, GC No. 14 §§ 30-52 and GC No. 15 §§ 51 and 71-74.

¹¹⁴ *Ibidem supra* note 110, GC No. 14, § 8; *Ibidem supra* note 111, GC No. 15, § 24.

¹¹⁵ *Ibidem supra* note 110, GC No. 14, § 11.

¹¹⁶ *Ibidem supra* note 111, GC No. 15, § 4.

by way of concrete measures required by States (see section 4.4).¹¹⁷ Generally speaking, it is indicated that countries with high income have the responsibility to help low-income (developing) countries in the realization of the right to health. On the other hand, low-income countries have a responsibility to seek appropriate international co-operation in order to strengthen their policies for the protection of their population's health and fulfil their core obligations arising from the right to health.¹¹⁸

All in all, although GCs No. 14 and No. 15 do not have binding legal authority, an elaboration of the right to health is attempted through the interpretation of the CESCR and the CRC Committee in these Comments, respectively. Note that the Special Rapporteur on the right to the highest attainable standard of health ('right to health') through his work has also attempted to reinforce the principles established in the respective GCs at the operational level (see section 4.2.3). In 2002, the then Commission on Human Rights appointed the first Special Rapporteur on the Right to Health with the obligation, *inter alia*, to conduct missions in various countries and submit reports on the realization of the right to health (founding UN Res 2002/31).¹¹⁹ The role of the Special Rapporteur as well as the distinctive features of the right to health as laid down in GCs No. 14 (CESCR) and 15 (CRC Committee) with respect to the nature of state measures required for the realization of the right to health are more fully addressed in subsequent Chapters. Last but not least, we should keep in mind, as rightly pointed out in literature, that GCs should not extend the scope of a treaty obligation from what is 'conventionally agreed' to 'what might be considered to be desirable' given that these documents do not have legal weight.¹²⁰ As such, Riedel pointedly observes that the CESCR,

¹¹⁷ Ibidem supra note 110, GC No. 14, §§ 38-41 and 45; Ibidem supra note 111, GC No. 15, §§ 86-89.

¹¹⁸ Ibidem supra note 110, GC No. 14, §§ 38-40 and 45; See, also, Section 4.4; Ibidem supra note 73, J. Asher 2004, p. 51.

¹¹⁹ Note by way of background that the Special Rapporteur on the Right to Health is required under the mandate to prepare reports that offer insights into the normative framework of the right to health and, ultimately, into its effective realization. These reports involve annual reports to the then Commission on Human Rights, the Human Rights Council and the UN GA, as will be discussed more elaborately in section 4.2.3; See website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>. See, UN Commission on Human Rights, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health -Resolution 2002/31*, 22 April 2002, UN Doc. E/CN.4/RES/2002/31, § 5.

¹²⁰ See, e.g., E. Riedel, 'The Human Right to Health: Conceptual Foundations' in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 27.

like all treaty bodies, has to ‘draw a fine line between interpreting ... and legislating, which is up to the contracting states’.¹²¹

2.3. HEALTH AS A RIGHT AT THE REGIONAL LEVEL: A FOCUS ON EUROPE

Generally speaking, three regional human rights systems have been mainly created for protecting human rights, including one in Europe, the Americas and Africa.¹²² Europe has the oldest human rights system within which considerable developments have taken place during the years.¹²³ Thereto, in terms of the examination of regional documentary sources of the right to health, the treaties that recognize the right to health and will be reviewed are key legally binding documents applicable in the European region.¹²⁴

European Human Rights System:

In Europe, both the Council of Europe (CoE) and the European Union (EU) aim to promote human rights in general and recognize the right to health in particular in diverse legal documents (see below). Most notably, within the context of the CoE, it was not until 1961 when the European Social Charter (ESC) enshrined a

¹²¹ Ibid., p. 27.

¹²² Ibidem supra note 22, H.J. Steiner et al. 2008, p. 925.

¹²³ Ibidem supra note 22, H.J. Steiner et al. 2008, pp. 925-926; Another reason to opt for the examination of the European human rights system in relation to the recognition of the right to health is that Part II of the study will focus on a European country, Greece.

¹²⁴ See other regional right to health provisions, e.g., Under the American Human Rights System: the American Declaration of the Rights and Duties of Man (ADHR, 1948) includes a general provision in Article 11; the American Convention on Human Rights (referred as Pact of San Jose, 1969) recognizes ESC rights in a single article, namely Article 26, without referring specifically to the right to health; the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador, 1988) includes a right to health provision in Article 10 and recognizes several other health-related rights, including, *inter alia*, Articles 9 (social security) and 11 (living in a healthy environment); Under the African Human Rights System: The African Charter on Human and People’s Rights (*Banjul Charter*, 1981) recognizes the right to health in Article 16; The African Charter on the Rights and Welfare of the Child (1990) includes a right to health provision in Article 14 as well as other health-related provisions: Articles 11§ 2 (h) on the promotion of children’s understanding of basic health care in schooling, 20 § 1 (b) on the parental responsibility for ensuring living conditions necessary for the development of the child and 20 § 2 (a) on appropriate measures to be taken by States to provide material assistance and support programs with respect to children’s health.

right to protection of health (Article 11) and in 1997 when the Biomedicine Convention proclaimed a right to equitable access to health care (Article 3). Thereby, this section will analyze the relevant key provisions on the right to health in the European region, namely relevant legal documents in the CoE, involving relevant case law of the European Court of Human Rights (ECtHR) and the European Committee of Social Rights (ECSR), and within the EU.

1 Article 11 (Revised) European Social Charter

During the drafting period of the ICESCR, the ESC¹²⁵ was also being drafted and adopted in 1961 to ensure economic and social human rights, among which a ‘right to protection of health’ under Article 11. Notably, a revised version of the ESC was adopted in 1996, as a way of ‘revitalizing’ the Charter that was perceived by its drafters as a need primarily as regards the strengthening of economic and social rights in the European region due to the emergence of liberalized market economies in the early 1990s in several Central and Eastern European countries.¹²⁶ Meanwhile, this revitalization process did not introduce substantial changes to the initial text of Article 11 ESC.¹²⁷ In particular, the (Revised) ESC includes in Article 11 a ‘right to protection of health’, by stipulating that contracting States, with a view to ensuring the effective exercise of this right, are required to undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed, *inter alia*: ‘1. to remove as far as possible the causes of ill-health’; ‘2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health’; and ‘3. to prevent as far as possible epidemic, endemic and other diseases as well as accidents’.¹²⁸

¹²⁵ European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) European Social Charter, 3 May 1996, entered into force 1 July 1999, ETS 163.; The only new element included in Article 11 Revised ESC is the phrase ‘as well as accidents’; Note also that as at 30 June 2016 the majority of the Member States of the CoE (i.e., 34 Member States out of total 47 Member States) have signed and ratified the (Revised) ESC, among which Greece (see Annex 2).

¹²⁶ See, e.g., G. de Beco, *Human Rights Monitoring Mechanisms of the Council of Europe*, London/ New York: Routledge 2012, p. 72 (citing relevant studies).

¹²⁷ *Ibidem supra* note 125; It is noteworthy that the content of the ESC was enriched and new Articles were included in the revised version of the Charter, such as Article 17, Article 30 and Article E that are relevant to the protection of health; *Ibid.*, G. de Beco 2012, pp. 73-74.

¹²⁸ ESC 1961 (Revised), adopted on 3 May 1996, entered into force on 1 July 1999, 2151 UNTS 277, ETS 163; See Annex 2.

Unlike the ICESCR and the CRC, the Charter does not include clauses on the progressive realization and on the availability of resources in relation to the realization of the rights enshrined in the Charter, such as the right to health.¹²⁹ Additionally, the (Revised) ESC in Article 11 employs different terminology to define health as a right; embraces individual responsibility in matters of health; pays attention to co-operation with public and private organizations as part of States' responsibility; and focuses on diverse health-related measures, even though it interprets the right to health in expansive terms just as in international human rights law (i.e., see Article 12 ICESCR, Article 24 CRC, etc.). At the same time, Article 11 (Revised) ESC highlights that the right to health is more than a right to medical care and it covers the causes of ill-health.¹³⁰ Indeed, as comprehensively explained by the Secretariat of ESC Article 11 (Revised) ESC provides for a broad framework of measures encompassing both health promotion and healthcare provision in case of sickness.¹³¹ In particular, health promotion involves preventive measures (i.e., healthy environment, immunization and epidemiological monitoring, prevention of accidents), health educational measures (i.e., personal behaviour, public awareness, counselling and screening) and the issuing and implementation of health regulations (i.e., occupational health and safety, children's health, maternal health and elderly person's health).¹³² Healthcare provision includes measures associated with the functioning of healthcare facilities and the overall system of health care as to be responsive to avoidable health risks and accessible to the entire population.¹³³

In the meantime, the (Revised) ESC contains several other extensive provisions which guarantee health-related rights and are relevant to the promotion and protection of health.¹³⁴ Particularly, Article 3 lays down obligations to ensure health and safety at work. Moreover, the Charter under Article 13 recognizes a right to social and medical assistance by stipulating that all nationals and people on the territory without adequate resources have the right to social and medical assistance in case of sickness. Further, the health and well-being of children and young persons are protected by Articles 7 (the right of children and young persons to protection) and 17 (the right of children and young persons to social, legal and economic

¹²⁹ Ibidem supra note 126, G. de Beco 2012, p. 74.

¹³⁰ Ibidem supra note 128.

¹³¹ The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009.

¹³² Ibid., pp. 2-9.

¹³³ Ibid., pp. 9-10.

¹³⁴ For health-related rights in the (Revised) ESC, see also Annex 1.

protection), while the health of pregnant women is addressed in Articles 8 (special protection for employed pregnant women) and 17 (the right of children and young persons to social, legal and economic protection). Additionally, the health of elderly persons is covered by Article 23, whilst the protection and assistance to migrants and their families are provided by Article 19. Finally, Articles 12 (the right to social security) and 14 (the right to benefit from social welfare services) are also health-related rights.¹³⁵

In light of the aforementioned provisions, it can be observed that the Charter pays particular attention to the position of vulnerable groups, namely children and young persons, women, migrant workers and their families, and elderly persons.¹³⁶ Added to these provisions, it is notable that the Charter embraces a non-discrimination clause in Article E (prohibition of all forms of discrimination in the application of the rights guaranteed by the treaty).¹³⁷ However, the scope of the Charter with regard to persons afforded protection is limited by its Appendix, including foreigners only in so far as they are nationals of other Contracting States lawfully resident or working regularly within the territory of the Party concerned.¹³⁸ The European Committee of Social Rights (ECSR) -the treaty monitoring body of the (Revised) ESC which allows the lodging of collective complaints in addition to the system of periodic reporting¹³⁹-, albeit aware of this provision, expanded the Charter's scope of application as to include non-nationals (e.g., undocumented migrants in certain circumstances) in its (non-binding) decisions (see section 4.3).¹⁴⁰

¹³⁵ Ibidem supra note 128; Annex 1.

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ (Revised) ESC – Appendix, § 1. It reads as follows: ‘Without prejudice to Article 12, paragraph 4, and Article 13, paragraph 4, the persons covered by Articles 1 to 17 and 20 to 31 include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned, subject to the understanding that these articles are to be interpreted in the light of the provisions of Articles 18 and 19.’

¹³⁹ The AP to ESC provided a system of collective complaints, adopted 9 November 1995 (entered into force in July 1998), CETS 158; See, Articles 1-2 AP ESC.

¹⁴⁰ See, e.g., *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint no. 14/2003, 3 November 2004, §§ 31-34 and §§ 36-37 - Notably, the ECSR found a violation of Article 17 (Revised) ESC which provides an expansive protection (social, legal and economic protection) with respect to children; *Defence for Children International (DCI) v. Belgium* (Complaint No. 69/2011, 20 November 2012) § 152- The ECSR found a violation of Articles 11(1) and (3), and 17 (Revised) ESC, and *Defence for Children International (DCI) v. The Netherlands* (Complaint No. 47/2008, 27 October 2009) §§ 25, 66 & 77 – The ECSR found a violation of Article 17(1)c (Revised) ESC which is applicable also to children unlawfully present in the Netherlands.

Last but not least, an interpretation of the right to health can be found in the case law of the ECSR, whose work can contribute to the advancement of the legal nature of the right to health, a contentious issue ever since the emergence of ESC rights (see section 4.3).¹⁴¹

2 Article 3 Biomedicine Convention

Another significant document drafted within the context of the CoE is the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Biomedicine Convention). While the right to health in the (Revised) ESC is recognized in expansive terms involving not only healthcare but also the underlying determinants of health, the Biomedicine Convention takes a narrower approach to this right by mainly focusing on access to healthcare. In particular, Article 3 stipulates that ‘parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality’.¹⁴²

Nonetheless, the formulation of Article 3 Biomedicine Convention does not provide clarity on its scope and the nature of measures required by States. To this aim, the Committee of Bioethics has provided an interpretation of Article 3 in the Explanatory Report to the Convention on Human Rights and Biomedicine.¹⁴³ Accordingly, the term ‘health care’ is interpreted as to encompass services offering diagnostic, preventive, therapeutic and rehabilitative interventions designed to maintain or enhance a person’s state of health or alleviate a person’s suffering.¹⁴⁴

¹⁴¹ See, e.g., J. Sellin, ‘Justiciability of the Right to Health - Access to Medicines. The South African and Indian Experience’, *Erasmus Law Review* 2009 Volume 2 Issue 4, pp.445-464, p. 451.

¹⁴² The Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine CETS No. 164 entered into force on 1 December 1999. As at 30 June 2016, 29 Member States of the CoE have ratified the Biomedicine Convention, among which Greece (see Annex 2). Note that several other provisions in the Biomedicine Convention are health-care related, such as Articles 5-9 (consent to treatment), 10 (private life and the right to information), 11-14 (genetics and the prohibition of discrimination), 15-18 (scientific research) and 19-22 (organ and tissue removal from living donors for transplantation purposes); For an overview of health-related rights in the Biomedicine Convention, see also Annex 1.

¹⁴³ Explanatory Report to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the application of biology and medicine, ETS No. 164.

¹⁴⁴ *Ibid.*, § 24.

In addition, the Explanatory Report observes that Article 3 imposes a general state obligation to ensure equitable access to health care of appropriate quality in accordance with a person's medical needs by requiring of States to use their best endeavors to realize this objective.¹⁴⁵ Also, the term 'equitable access to health care' implies 'first and foremost the absence of unjustified discrimination'¹⁴⁶ and ensuring a satisfactory degree of care¹⁴⁷. Aasen pointedly argues that this wording must be understood as to encompass a consideration for the particular and diverse needs of all population groups in the society by way of adopting targeted interventions on the part of States.¹⁴⁸

All in all, we can conclude that the wording of Article 3 implies only in principle a narrower scope than Articles 11 (Revised) ESC (CoE level) and 12 ICESCR (UN level), as its implementation requires States to design an elaborated framework of measures, not just in the area of healthcare. In essence, given that some determinants of health have an effect on access to healthcare (i.e., socio-economic determinants) and are beyond the control of healthcare, the implementation of the general state obligation under Article 3 involves also the consideration of such health determinants on the part of the States within the context of designing targeted health policies to achieve this end.¹⁴⁹

3 *European Convention for the Protection of Human Rights and Fundamental Freedoms*

Within the context of the CoE, the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950) is another regional legal source which is essentially concerned with the protection of CP rights (life, privacy etc.) and not with ESC rights, like the right to health.¹⁵⁰ Even though the right to

¹⁴⁵ Ibid., §§ 23-24.

¹⁴⁶ Ibid., § 25.

¹⁴⁷ Ibid., § 25.

¹⁴⁸ H.S. Aasen 'The Right to Health Protection for the Elderly: Key Elements and State Obligations', in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 273-299, p. 285.

¹⁴⁹ Ibid., see for a similar approach as to the scope of Article 3 Biomedicine Convention.

¹⁵⁰ European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) adopted 4 November 1950, entered into force 3 September 1953, 213 UNTS 221, CETS No. 005. Note that all 47 Member States of the CoE, among which Greece, have ratified the ECHR and that the accession of the EU to the ECHR has become a legal obligation under the Treaty of Lisbon (legal basis: Article 59 § 2 ECHR as amended by Protocol No. 14 to the ECHR which entered into force on 1 June

health is not enshrined in the ECHR, the ECtHR has illustrated through its legally binding judgments that the ECHR encompasses several other rights that are health-related and whose enjoyment has implications in the field of health (care)¹⁵¹, involving *inter alia* the right to life (Article 2)¹⁵², the prohibition of torture (Article 3)¹⁵³ and the right to private and family life (Article 8)¹⁵⁴, and the prohibition of discrimination (Article 14).¹⁵⁵

By way of example we can discern that Article 3 ECHR, which prohibits torture and inhuman or degrading treatment, can be perhaps an effective tool for the indirect protection of health.¹⁵⁶ In fact, the ECtHR, as will be elaborately discussed in section 7.4.1, has found that solely in ‘exceptional circumstances’ (i.e., ‘critical stage in an individual’s fatal illness’) the expulsion of a person with

2010); See also, I. Brownlie & G.S. Goodwin-Gill, *Brownlie’s Documents on Human Rights* (6th ed.), Oxford: Oxford University Press 2010, p. 681.

¹⁵¹ Under Article 34 ECHR any individual, non-governmental organization or group of individuals are entitled to lodge complaints with the ECtHR concerning claims on a violation of the rights set forth in the ECHR by one of the State parties of ECHR. See, e.g., A. Hendriks, ‘The Council of Europe and Health and Human Rights’, in: B. Toebes, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 23-50, p. 27; For health-related rights in the ECHR, see Annex 1.

¹⁵² For case law of the ECtHR with relevance in the field of health that has been argued under Article 2 ECHR (i.e., involving issues, such as physical ill-treatment, protection of health of individuals, denial of health care, medical negligence) see, e.g., *Erikson v. Italy* (Application no. 37900/97) ECtHR 26 October 1999; *Cyprus v. Turkey* (Application no. 25781/94) ECtHR 10 May 2001, § 219; *Oyal v. Turkey* (Application no. 4864/05) ECtHR 23 March 2010, §§ 66-69.

¹⁵³ For health-related case law of the ECtHR that has been argued under Article 3 ECHR (i.e., involving issues such as damage of an individual’s physical/mental health) see, e.g., *Paladi v. Moldova* (Application no. 39806/05), ECtHR 10 March 2009; *Kaçiu and Kotorri v. Albania* (Application nos. 33192/07 and 33194/07) ECtHR 25 June 2013, §§ 89, 98 and 100; *Gäfgen v. Germany* (Application no.22978/05) ECtHR 1 June 2010, §§ 79 and 131-132.

¹⁵⁴ For health-related case law of the ECtHR that has been argued under Article 8 ECHR (i.e., involving issues, such as the respect of an individual’s physical and psychological integrity, personal autonomy – refusal of proposed medical treatment) see, e.g., *Glass v. the United Kingdom* (Application no. 61827/00) ECtHR 9 March 2004, §§ 70-83; *Tysiak v. Poland* (Application no. 5410/03) ECtHR 20 March 2007, §§ 105-108.

¹⁵⁵ For health-related case law of the ECtHR that has been argued under Article 14 ECHR (i.e., involving issues, such as a person’s health status constitutes a protected ground against discrimination) see, e.g., *Kiyutin v. Russia* (Application no. 2700/10) ECtHR 10 March 2011, §§ 9 and 57; *I.B. v. Greece* (Application no. 552/10) ECtHR 3 October 2013, § 73.

¹⁵⁶ *Ibid.*; *Ibidem supra* notes 150 and 151.

a life-threatening disease to a country lacking essential medical care would amount to inhuman treatment and constitute a violation of Article 3 ECHR.¹⁵⁷ Nonetheless, the Court by emphasizing the exceptional character of the particular case expressed its hesitance to engage such a positive state obligation under the Convention in similar cases (i.e., the deportation of a seriously ill individual to his or her country of origin) where the individual's illness does not reach a terminal stage (i.e., imminent death or serious physical and mental suffering).¹⁵⁸ As such, we can conclude that the decisions of the ECtHR on a (alleged) risk of ill-treatment in deportation cases will be each time determined by the particular circumstances of each individual case brought before it.

4 Article 35 of Charter of Fundamental Rights of the European Union

At EU level, Article 35 of Charter of Fundamental Rights of the European Union (CFREU, 2000) stipulates a right to health in the sense that '*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established under national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*' [emphasis added].¹⁵⁹ From the aforementioned provision two basic legal implications arise. This provision forms the basis of the individual entitlements of EU citizens to both preventive health care and to medical treatment under the conditions set by individual European Countries.¹⁶⁰ Additionally, it establishes an obligation on the EU institutions in terms of Community policies and activities of the Union, to the extent that the EU has competence.¹⁶¹ Nonetheless,

¹⁵⁷ *D. v. the United Kingdom* (Application no. 30240/96) ECtHR 2 May 1997, §§ 53- 54.

¹⁵⁸ Note that in 'similar' cases to that of *D. v the United Kingdom*, namely when the availability of treatment in country of destination in conjunction with the healthcare needs of an individual has been invoked against a decision on expulsion, the ECtHR held otherwise, see, e.g., *N. v. the United Kingdom* (Application no. 26565/05), ECtHR 27 May 2008; *Salkic and Others v. Sweden* (Application no. 7702/04), ECtHR 29 June 2004, p. 10; *Ndangoya v. Sweden* (Application no. 17868/03) ECtHR 22 June 2004, p. 13; *Arcila Henao v. the Netherlands* (Application no. 13669/03), ECtHR 24 June 2003, p. 8; *Bensaid v. the United Kingdom* (Application no. 44599/98), ECtHR 6 February 2001, § 38.

¹⁵⁹ Charter of Fundamental Rights of the European Union, *Official Journal of the European Communities*, Doc. 2000/C 364/01. Of note, the Charter has become legally binding on the EU with the entry into force of the Treaty of Lisbon on 1 December 2009, Article 6 § 1 TFEU (see infra note 165). <http://www.europarl.europa.eu/charter/pdf/text_en.pdf>

¹⁶⁰ *Ibid.*; For a similar approach see, e.g., *Ibidem supra* note 148, H.S. Aasen 2012, p. 234.

¹⁶¹ As to the scope of the Charter, see Article 51 CFREU. Note that Article 51§ 1 CFREU

given the broad formulation of this provision, its wording is not explicit on the issue whether non-nationals, such as undocumented migrants, are entitled to access preventive health care and to benefit from medical treatment.¹⁶² This provision gives discretionary power to individual European Countries to decide on this issue through the elaboration of their own health policy. Indeed, some scholars argue that the broad wording of the provisions of the Charter may be problematic when it comes to be applied¹⁶³, while others argue that these provisions are likely to be qualified in practice -albeit phrased in absolute terms- when they are interpreted and applied.¹⁶⁴

Meanwhile, the wording of Article 35 CFREU is similar to that of Article 168 Treaty on the Functioning of the European Union (TFEU), which replaced Article 152 EC Treaty (TEC) with the adoption of the Lisbon Treaty (2009).¹⁶⁵ Article 168 § 1 states that ‘A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities’.¹⁶⁶ This provision is further elaborated in Article 168 § 7 which stipulates that the Union ‘shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them’.¹⁶⁷ The TFEU makes it explicit that Member States have the prime competence over the design and development of health care. At this stage, it is important to note that the Union can regulate this competence (see Article 168 § 4 (a)-(c) TFEU) through several actions-mechanisms. For instance, under Article 288 TFEU this could be achieved

provides that the institutions and bodies of the EU as well as the Member States, to whom the Charter is addressed shall ‘respect the rights, observe the principles and promote the application thereof *in accordance with their respective powers*’ [emphasis added].

¹⁶² See, e.g., Ibidem supra note 148, H.S. Aasen 2012, p. 235, see for an analogous approach.

¹⁶³ See, e.g., Ibidem supra note 103, J. Rothmar Herrmann & B. Toebe 2012, pp. 51-79, p. 57.

¹⁶⁴ See, e.g., J. McHale, ‘Fundamental rights and health care’, in: El. Mossialos, G. Permanand, R. Baeten and T.K. Hervey, *Health Systems Governance in Europe: The Role of European Union Law and Policy*, Cambridge: Cambridge University Press 2010, pp. 282-314, p. 298.

¹⁶⁵ Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, signed at Lisbon 13 December 2007, *Official Journal of the European Union*, 17 December 2007, Doc. 2007/C 306/01. Available at <www.eur-lex.europa.eu>

¹⁶⁶ Consolidated Version of the Treaty of on the Functioning of the European Union, *Official Journal of the European Union*, 26 October 2012, Doc. 2012/C 326/47. Available at <www.eur-lex.europa.eu>

¹⁶⁷ Ibid.

by way of issuing Directives (i.e., EU secondary law within EU legal order) that have implications in the area of health and as such they can provide a common legal framework across all EU Member States when they are addressed to all these States (e.g., see Racial Equality Directive 2000/43/EC - Part II, section 8.3.2).¹⁶⁸

Nevertheless, since the emergence of the economic crisis within the EU (2009-2010), several EU Member States, such as Greece (see Part II), have gradually introduced a number of austerity measures in the health sector in order to address the hardly manageable rising health care costs. Such initiatives may be translated into more and increasing user fees for health care, which in turn may adversely impact on disadvantaged groups within the population (i.e., such as chronically ill, Roma, undocumented migrants) and increase their vulnerability, as a result. As such, one cannot ignore the fact that such initiatives further contribute to the rising socio-economic health inequalities in the EU (see Part II, chapter 6). Indeed, Hendriks pointedly argues that the EU's competences in the area of healthcare remain rather limited notwithstanding the entering into force of the TFEU (2009) and the CFREU (2009).¹⁶⁹

2.4. HEALTH AS A RIGHT AT THE NATIONAL LEVEL: CONSTITUTIONAL PROVISIONS

The right to health, however phrased at the international and regional level, is also found to be enshrined in national constitutional law. Illuminating perhaps is the report by the first UN Special Rapporteur on the Right to Health (Paul Hunt) where he stresses that the right to health or the right to healthcare is included in over 60 national constitutions and more than 40 national constitutions contain health-related rights, such as the right to reproductive health or the right to a healthy environment.¹⁷⁰ Hence, this section examines a compilation of explicit or implicit

¹⁶⁸ For a definition of the term 'Directive' see website of the EU <http://europa.eu/eu-law/decision-making/legal-acts/index_en.htm>. Note that Article 288 TFEU provides that each EU country will decide on the way of applying an EU Directive within its legal order for achieving the goals set under the Directive.

¹⁶⁹ A. Hendriks, 'High-quality of Care throughout Europe — But Do We Speak the Same Language?' (editorial), *European Journal of Health Law* 2016, 23, pp. 1-4, p.1.

¹⁷⁰ UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, § 20; *Ibidem* supra note 14, E.D. Kinney & B. Clark 2004, pp. 285-355; WHO Regional Office for South-East Asia, *The Right to Health in the Constitutions of the Member States of the World Health Organization South-East Asia Region*, India: WHO 2011.

references to health as a right in national constitutions with a primary focus on Europe.¹⁷¹ Particularly, a number of constitutional provisions, which illustrate the various dimensions of the interpretation of the right to health as well as the different types of constitutional provisions, will be mentioned in an exemplary manner.¹⁷² In some of the constitutional provisions mentioned, it becomes clear that health is a constitutionally protected right, whereas in others it may only be regarded as a state obligation (see below).

More specifically, several constitutional provisions have taken various forms with clauses referring either directly or indirectly to the right to health. The Constitution of Hungary, for example, in its first paragraph of Article XX sets forth ‘the right to physical and mental health’.¹⁷³ Here, the right to health is worded in very similar language to that of Article 12 ICESCR. Furthermore, the second paragraph of Article XX of the Constitution contains a list of seven areas of a State’s responsibility. Meanwhile, Article XXI of the Constitution recognizes a right to a healthy environment. In addition, the Constitution of Italy contains an individual right to health.¹⁷⁴ Moreover, Greece¹⁷⁵, Portugal¹⁷⁶, Romania¹⁷⁷, Slovakia¹⁷⁸, Estonia¹⁷⁹ and Spain¹⁸⁰ have constitutional provisions that include an explicit right to protection of health and establish state obligations for the promotion of the health. Furthermore, Bulgaria and Slovenia in their constitutions provide explicitly for a right to health care rather than a right to health, which is made subject to insurance and national legal conditions, as well as establish specific state obligations to guarantee the protection of their population’s health.¹⁸¹

Further, it is noteworthy that other countries do not have an individual right

¹⁷¹ Ibid.; The constitutions listed in this section are available at the following web sites: constitution finder, <<http://www.confunder.richmond.edu>> and <<http://www.wipo.int/wipolex/en>>; See generally, e.g., G. Robbers (ed.), *Encyclopedia of world constitutions*, 3-Volume set, NY: Infobase publishing 2007.

¹⁷² Status of Constitutional Provisions as at 30 June 2016.

¹⁷³ Constitution of Hungary (The Fundamental Law of Hungary, 2011, repealed the Constitution of 1949, as amended to 2013), Article XX (1).

¹⁷⁴ Constitution of Italy (1947, as amended to 2012), Article 32.

¹⁷⁵ Constitution of Greece (1975, as amended to 2008), Articles 5 § 5 and 21 § 3.

¹⁷⁶ Constitution of Portugal (1976, as amended to 2005), Article 64.

¹⁷⁷ Constitution of Romania (1991, as amended to 2003), Article 34.

¹⁷⁸ Constitution of Slovakia (1992, as amended to 2014), Article 40.

¹⁷⁹ Constitution of Estonia (1992, as amended to 2011), Article 28.

¹⁸⁰ Constitution of Spain (1978, as amended to 2011), Sections 43 and 50.

¹⁸¹ Constitution of Bulgaria (1991, as amended to 2007), Article 52 and Constitution of Slovenia (1991, as amended to 2013), Article 51.

to health enshrined in their constitutions, but nevertheless approach it from the angle of state obligations with respect to health, namely to provide health care or to improve public health. The word ‘right’ is not depicted in these constitutions. For instance, Luxembourg¹⁸², Switzerland¹⁸³, Latvia¹⁸⁴, Liechtenstein¹⁸⁵ and Netherlands¹⁸⁶ have constitutional provisions that define the state’s duty either to provide medical aid or to protect human health or to maintain public health or to promote the health of the population, respectively. Additionally, the constitution of Switzerland under Article 118 § 2 establishes specific state obligations for the protection of health.

In the meantime, other countries include the right to health in broader constitutional provisions on welfare, social security, life and human dignity, while others restrict the right to health to principles of State policy. For instance, the right to health is enshrined in the Constitution of Finland as part of a provision covering the right to social security.¹⁸⁷ Likewise, the right to health, stipulated in the Belgian Constitution, is directly related to the right to life and human dignity.¹⁸⁸ Notably, in the Indian Constitution health is covered in terms of the ‘Directive Principles of State Policy’ by establishing a clear role for the State in public health policy.¹⁸⁹

All in all, this non-exhaustive analysis of a number of constitutional provisions reveals that the right to health has received different approaches in the various national constitutions. While some constitutions expressly include provisions for it (e.g., a right to protection of one’s health), others have no single provision on the right to health and this right is rather inferred from other rights. At the same time, in some countries the right to health is restricted to principles of State policy (i.e., to the establishment of a role for the State in health policy). Nevertheless, we may conclude that however codified, the recognition of the right to health in national constitutional law tends to provide a path for enhanced protection and promotion of health at the national level (see Part II, chapter 5).

¹⁸² Constitution of Luxembourg (1868, as amended to 2009), Article 23.

¹⁸³ Constitution of Switzerland, (1999, as amended to 2014), Articles 12, 41 § 1(b) and 118.

¹⁸⁴ Constitution of Latvia (1922 reinstated 1991, as amended to 2014), Article 111.

¹⁸⁵ Constitution of the Principality of Liechtenstein (1921, as amended to 2010), Article 18.

¹⁸⁶ Constitution of Netherlands (1815, as amended to 1983-2008), Article 22 § 1.

¹⁸⁷ Constitution of Finland (1999, as amended to 2011), Section 19.

¹⁸⁸ Constitution of Belgium (1831, as amended to 2014), Article 23.

¹⁸⁹ Constitution of India (1949, as amended to 2015), Article 47.

2.5. THE RIGHT TO HEALTH AND OTHER HUMAN RIGHTS

While the internationally guaranteed right to health is a key right, it is noteworthy that several other human rights have the potential to protect health and are relevant in a healthcare domain, as already mentioned in previous sections.¹⁹⁰ In particular, several human rights retain a health dimension and are connected to health, including the right to life, the right to freedom from inhuman and degrading treatment, the right to privacy, the right to information and the right to a private and family life (see also Annex 1). It can, thus, be argued that the right to health is interdependent with such rights. Enjoyment of the right to health, as its definition makes clear, requires among other things respect for several other rights that are integral components of the right, as pointed out by the CESCR's interpretation on the right to health in its GC No. 14.¹⁹¹ This reflects the indivisibility and interdependence of all human rights¹⁹², as was affirmed in the Vienna Declaration and Programme of Action, adopted in 1993.¹⁹³ In this spirit, in scholarly writings it is maintained, for example, that 'the goal of linking health and human rights is to contribute to advancing human well-being beyond what could be achieved through an isolated health- or human rights-based approach'.¹⁹⁴

Notably, the right to health as defined in GC No. 14 is closely related to and dependent upon the realization of a number of other human rights, as contained in the International Bill of Rights,¹⁹⁵ which are related not only to the social determinants of health (e.g., housing, education, food and work), but also to civil

¹⁹⁰ Ibidem supra note 110, GC No. 14, § 3; See, e.g., R.J. Cook & M.F. Fathalla 'Advancing Reproductive Rights Beyond Cairo and Beijing' *International Family Planning Perspectives* Sep., 1996, 22, no. 3, pp. 115-121, p. 116; B. Toebe, 'The Right to Health and Other Health-Related Rights' in: B. Toebe, M. Hartlev, A. Hendriks & J. Rothmar Herrmann (eds.), *Health and Human Rights in Europe*, Cambridge/Antwerp/Portland: Intersentia 2012, pp. 83-110, p. 83.

¹⁹¹ Ibidem supra note 110, GC No. 14, § 1 and GC No. 22, § 1.

¹⁹² E.g., a failure to protect health (e.g., right to health, an ESC right) may result in a threat to life (a CP right). See, e.g., CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Commission on Social Determinants of Health - Final Report*, Geneva: World Health Organization 2008; B. Wilson, 'Social Determinants of Health from a Rights-Based Approach', in: A. Clapham & M. Robinson (eds.), *Realizing the Right to Health*, Zurich: Rüffer & Rub 2009, pp. 60-79, p. 60.

¹⁹³ Vienna Declaration and Programme of Action, UN Doc. A/Conf.157/23, August 1993, § 5 section I.

¹⁹⁴ Ibidem supra note 12, J.M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini & H. Fineberg 1999, pp. 7-20, p. 11.

¹⁹⁵ The International Bill of Rights consists of the UDHR, ICESCR and ICCPR.

and political rights, such as life, the prohibition against torture.¹⁹⁶ In other words, this means that special attention must be paid to ensure the interdependence of other health-related rights with the right to health and not to conflate their normative framework with that of the right to health and, thereby, deny their distinct content.¹⁹⁷ Moreover, these rights which address integral components of the right to health (i.e., are essential for human health) in conjunction with the right to health oblige States to enhance the health and well-being of individuals (see section 3.2).¹⁹⁸

At this point, it should be noted that this section does not aim to further elaborate upon all other health-related rights, as it goes beyond the scope of this chapter. Nevertheless, the relevance of such human rights for the enjoyment of the right to health will be further addressed, where relevant, in subsequent chapters as well as a table in Annex 1 gives an overview of several health-related rights.

2.6. CONCLUSIONS

The above analysis of the key formulations of health as a right at the international, regional and national level provides an important insight into the broad notion of the right to the highest attainable standard of health and the state obligations arising from it. It becomes clear that the right to health is a firmly established feature of binding human rights law and is embedded in a significant number of international and regional human rights documents as well as of national constitutions.¹⁹⁹ The depiction of health as a right in the WHO Constitution as well as in Article 12 ICESCR constitutes an expansive framework within which to conceive legislative as well as policy measures for realizing the right to health at national level. Subsequent to the ICESCR other international human rights treaties were adopted like the CRC, the CEDAW, the CRPD, which affirmed and expanded the application of the right to health as it is addressed to different target-groups (i.e., children, women and persons with disabilities etc.). These international human rights documents are relatively more specific in their wording, character and scope than Article 12 ICESCR and as such they provide more protection to the groups concerned than the broadly formulated Article 12 ICESCR. Moreover, at the

¹⁹⁶ Ibidem supra note 110, GC No. 14, § 3.

¹⁹⁷ Ibidem supra note 11, B.C.A. Toebes 1999, pp. 259-260.

¹⁹⁸ Ibidem supra note 110, GC No. 14, §§ 1 & 3.

¹⁹⁹ See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, § 15.

European level, most notably Article 11 (Revised) ESC uses a different terminology than that of Article 12 ICESCR to define the right to health as well as further expands the scope of the right to health by way of an elaborated framework of measures required by States.

However defined (e.g., a 'right to the highest attainable standard of health' or a right to protection of health etc.), the right to health is articulated in most provisions in human rights law which also impose a series of measures on States in order to secure the full implementation of this right. Such measures do not solely focus on obligations concerning access to health care, but range from an obligation to reduce infant mortality to an obligation to develop preventive health care and family planning services, to ensure occupational and environmental health, clean drinking water and adequate sanitation that form the underlying determinants of health. Nevertheless, exceptions in this respect constitute Articles 28, 43 and 45 MWC (at international level) as well as Article 3 of the Biomedicine Convention (at regional level) which only refer to access to health care. Thus, given the broad character of the measures required by States for realizing the right to health there is a need to clarify the type and scope of state obligations in a way to identify practical steps in terms of securing their effective implementation on the part of the States. It is this issue that subsequent chapters seek to address. All in all, despite the recognition of the right to health worldwide, there is still absence of consensus and much confusion exists on the content and implementation of this right due to a lack of conceptual clarity about its meaning and its various aspects under human rights law.

In addition to the treaty provisions, the CESCR and the CRC Committee adopted GC No. 14 (2000) and GC No. 15 (2013) on the right to health, respectively for providing an authoritative explanation of the meaning and implications of Articles 12 ICESCR and 24 CRC, respectively. Meanwhile, at the international level there are several other key international documents that tend to provide an interpretation of and/or are related to the right to health, including declarations, recommendations, plans, and regulations. Such documents have the potential to frame the standards and principles that national health legislation and policies should reflect. Most notably, the International Health Regulations (IHR) adopted by WHO in 2005 acknowledge in a binding manner the significance of human rights protection in case of health emergencies of international concern as well as reflect the general consensus of the international community on the close linkages between health and human rights. As will be elaborately analysed in subsequent chapters, of further importance is that the enjoyment of the right to health is inextricably connected to and reinforced by other rights -civil and

political rights as well as economic, social and cultural rights-which address its integral components.²⁰⁰

Finally, the additional value of the right to the highest attainable standard of health as formulated in human rights law is its translation into operational policies, programmes and health-related interventions within countries. Chapter 2 set a platform for further analysis in subsequent chapters of the normative framework of the right to health and its connection to other rights in terms of examining a specific country case study in Part II.

²⁰⁰ Ibidem supra note 198.

